

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06482

CERTIFICATE OF DEATH

06469

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Denton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Denton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) Garfield First Bilbrough Middle Lost		4. DATE OF DEATH Month 5 Day 28 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-1883
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Bilbrough		14. MOTHER'S MAIDEN NAME Katherine Alwine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-44-6656	
17. INFORMANT Mary Faithful Greensboro, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic C.V.Disease DUE TO (c) Arteriosclerotic C.V.Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 5, 1966 to May 28, 1967 , that (I) (we) last saw the deceased alive on May 28, 1967 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE <i>Charles H. Stonesifer</i>		22b. DATE SIGNED May 30 '67	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22d. ADDRESS Greensboro, Md. 21639	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-31-67	23c. NAME OF CEMETERY OR CREMATORY Greensboro	23d. LOCATION (City or Town) (County) (State) Greensboro, Md.
24. FUNERAL DIRECTOR <i>J.E. Boulaie</i>		25a. REC'D BY REGISTRAR DATE JUN 2 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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40 Yr. 40 Yr. 40 Yr.

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x

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None

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Garfield

12-25-10 32 x

White

USA

Marvin

Marvin

Marvin

Katherine

Katherine

21-12-10 32 x

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Greenboro, NC.

Greenboro, NC.

Greenboro, NC.

FOR STATE
HEALTH DEPT.

06483

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06470

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		c. LENGTH OF STAY IN fb 6 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Christopher Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton, d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) Edith Mae Henry Colborn		4. DATE OF DEATH Month May Day 7 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-1914
9. AGE (In years last birthday) yrs. 52		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Arthur Anthony	
14. MOTHER'S MAIDEN NAME Rella Smith		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 216-09-7792		17. INFORMANT Address Albert N. Henry Denton, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation chronic with DUE TO (b) left ventricular Dilatation & hypertrophy DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertthyroidism			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Harold B. Plummer M.D. EXAMINER'S NAME (Type) Harold B. Plummer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 5/8/67		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 5-10-67		23c. NAME OF CEMETERY OR CREMATORY Denton	
23d. LOCATION (City or Town) (County) (State) Denton, Maryland		24. FUNERAL DIRECTOR ADDRESS J. E. Bouleais Greensboro, Md.	
25a. REC'D BY REGISTRAR DATE MAY 10 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06484

CERTIFICATE OF DEATH

06471

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HILLSBORO</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HILLSBORO</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>WILLIAM ALBERT COLLINS</u>		4. DATE OF DEATH <u>MAY 27 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 7, 1903</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>GEORGE T. COLLINS</u>		14. MOTHER'S MAIDEN NAME <u>NETTIE WARNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. W. Albert Collins</u>		Address <u>Hillsboro</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastases to cerebral cortex</u> <u>163x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the lung</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1963</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1967</u> to <u>May 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 1967</u> , and that death occurred at <u>6:30 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Kurt Lederer</u>		22b. DATE SIGNED <u>May 29, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u>		22d. ADDRESS <u>QUEEN ANNE MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>MAY 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>	23d. LOCATION (City or Town) (County) (State) <u>HILLSBORO MD.</u>
24. FUNERAL DIRECTOR <u>Charles Woods Denton Inc.</u>		25. REC'D BY REGISTRAR <u>JUN 2 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

17440

CERTIFICATE OF DEATH

25430

Notary Public for the State of New York
in and for the County of New York

Kurt Lederer
Kurt Lederer

Green Anne

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MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06485

CERTIFICATE OF DEATH

06472

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. CITY OR TOWN MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DENTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DENTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 00		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) SAMUEL TAYLOR JOPP		4. DATE OF DEATH MAY 8 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 12, 1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHOTOGRAPHER		10b. KIND OF BUSINESS OR INDUSTRY NO RYLAND	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME W.M. HENRY JOPP		14. MOTHER'S MAIDEN NAME MARY ELLEN TAYLOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 000-00-0000	
17. INFORMANT Mrs Florence Jopp Denton		Address Denton	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Fibrosis DUE TO (c) Generalized Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nutritional Anemia			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr. 28 , 19 67 , to May 8 , 19 67 , that (I) (we) last saw the deceased alive on May 8 , 19 67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Charles H. Stonesifer		22b. DATE SIGNED May 9, 1967	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22d. ADDRESS Greensboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF May 10, 1967	23c. NAME OF CEMETERY OR CREMATORY DENTON	23d. LOCATION (City or Town) (County) (State) DENTON MD.
24. FUNERAL DIRECTOR JUBRCEL MOORE		25a. RECEIVED BY REGISTRAR MAY 15 1967	
ADDRESS DENTON		25b. REGISTRAR'S SIGNATURE J. Moore	

57400

OFFICE OF THE SECRETARY OF THE ARMY

57400

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06486

CERTIFICATE OF DEATH

06473

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				d. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) Ethel Elizabeth Quimby				4. DATE OF DEATH Month May Day 20 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1902		9. AGE (in years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME No Record				14. MOTHER'S MAIDEN NAME Daisey Tribbitt			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-34-9248D		17. INFORMANT Breeding Address Md. Greensboro			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V.Dis. with Hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 10, 1966 , to May 20, 1967 , that (I) (we) last saw the deceased alive on May 19, 1967 , and that death occurred at M , from causes and on the date stated above.							
22a. SIGNATURE <i>Charles H. Stonesifer</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 22 '67	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.				22d. ADDRESS Greensboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-23-67		23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION (City or Town) (County) (State) Greensboro, Md.	
24. FUNERAL DIRECTOR <i>J.E. Bouleais</i>				25a. REC'D BY REGISTRAR MAY 26 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06487					06474				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Caroline			a. STATE		Maryland		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Greensboro			b. COUNTY		Caroline		
c. LENGTH OF STAY IN 1b		Minutes			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Goldsboro		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
					None				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First		Middle		Last		Month		Day Year	
Annette				Snively		5		9 1967	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	Col	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 19, 1966		yrs. 10		Months 20		Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
None			None		Maryland		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Unknown					Annette Snively				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		None		Caroline Co. Welfare		Denton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a)									
Occlusion of the bronchus and atelectasis caused by aspiration of mucus									
DUE TO									
Chronic Bronchiolitis									
Chronic Bronchial Asthma									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
Brain damage due to Neonatal anoxia, probable hydrocephalus									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
Hour a.m. p.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
21. I certify that (I) (this hospital) attended the deceased from July 23, 1966, to May 9, 1967, that (I) (we) last saw the deceased alive on May 9, 1967, and that death occurred at M, from the causes and on the date stated above.									
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
Charles H. Stoner									May 9, 1967
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
Charles H. Stoner, M.D.					Greensboro, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		5-11-67		Cokers		Greensboro, Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J. E. Boulaie, Greensboro, Md.					MAY 15 1967		Charles Judge		

6-30

68174

68174

Carolina

Carolina

Carolina

Goldstone

Minster

Greenboro

None

Privately

Annette

June 12, 1968

Female

USA

Maryland

None

None

Annette Privately

Unknown

Caroline Co. Police Station, Md.

No

Continuation of information and details
to be added in subsequent reports

Caroline Co. Police Station

Caroline Co. Police Station

Continuation of information and details
to be added in subsequent reports

July 22 1968

27

2, 1967

Greenboro, Md.

Greenboro, Md.

Greenboro, Md.

Cokers

8-11-67

Burial

MAY 12 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MD 20-1
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M
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06488

CERTIFICATE OF DEATH

06475

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HILLSBORO</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HILLSBORO</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ADELINE</u> <u>TITOMAS</u> <u>STANTON</u>		4. DATE OF DEATH Month Day Year <u>May</u> <u>6</u> <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 6, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>75</u>
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM E. TITOMAS</u>		14. MOTHER'S MAIDEN NAME <u>AMELIA J. NICHOLS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Georgia Truxon, Hillsboro</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of the liver</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Adenocarcinoma of the stomach</u> DUE TO (c) <u>Xenos</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6 Sept 1967</u> to <u>May 6, 1967</u> that (I) (we) last saw the deceased alive on <u>May 6, 1967</u> and that death occurred at <u>10:20 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Kurt Lederer</u>		22b. DATE SIGNED <u>May 9, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u>		22d. ADDRESS <u>QUEEN ANNE MD</u>	
23a. BURIAL CREMATION REMOVAL <u>BURIAL</u>	23b. DATE THEREOF <u>May 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DAND TOWN</u>	23d. LOCATION (City or Town) (County) (State) <u>HILLSBORO MD</u>
24. FUNERAL DIRECTOR <u>J. VARGEL MOORE</u>		25a. REC'D BY REGISTRAR <u>DENTON</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAY 12 1967</u>	

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CENTRAL

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[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side.]

MAY 12 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
06489					06476				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>Caroline</u>					a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Federalsburg - Rural</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg - Rural</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bridgeville Road</u>					d. STREET ADDRESS <u>Bridgeville Road</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH		Month Day Year	
			<u>CLARENCE GARRISON TAYLOR</u>			<u>May</u>		<u>27</u> <u>1967</u>	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
<u>Male</u>		<u>White</u>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<u>May 15, 1904</u>		<u>63</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Night Watchman at Maryland Plastics, Inc.</u>				<u>Maryland Plastics, Inc.</u>		<u>Sussex County, Del.</u>		<u>USA</u>	
13. FATHER'S NAME <u>Hugh G. Taylor</u>					14. MOTHER'S MAIDEN NAME <u>Jennie Smith</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address				
<u>No</u>			<u>213-03-9667</u>		<u>Mrs. Virgie Taylor, Federalsburg, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1201</u> (c) <u>12 hrs</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
Hour a.m. p.m. <u>19</u>			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						
21. I certify that (I) (this hospital) attended the deceased from <u>5-27-67</u> , 19 <u>67</u> , to <u>5-27-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>5-27-67</u> , and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Frank M. Anderson</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 29, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Frank M. Anderson, M.D.</u>					22d. ADDRESS <u>Federalsburg, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
<u>Burial</u>			<u>May 29, 1967</u>		<u>Hill Crest Cemetery</u>		<u>Federalsburg, Maryland</u>		
24. FUNERAL DIRECTOR <u>J. J. Frampton and Son</u> ADDRESS <u>Federalsburg, Maryland</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06490					06477						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <u>Caroline</u> <u>MARYLAND</u>					a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Federalsburg - Rural</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Federalsburg - Rural</u>						
c. LENGTH OF STAY IN 1b <u>75 years</u>					d. STREET ADDRESS <u>Bridgeville Road</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bridgeville Road</u>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE		
First <u>JANE</u> Middle <u>TODD</u> Last <u>WHITE</u>			Month <u>May</u> Day <u>16</u> Year <u>19 67</u>			<u>Female</u>			<u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>April 14, 1874</u>			9. AGE (In years last birthday) <u>93 yrs.</u>			10. FUNERAL 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Ridgeway, North Carolina</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Edward Henry Bowman</u>						14. MOTHER'S MAIDEN NAME <u>Phoebe Elizabeth Burns</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>-----</u>			17. INFORMANT <u>Mrs. Mary E. Handy, Seaford, Del., RFD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinomatosis</u> DUE TO (c) <u>Carcinoma - breast</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>									INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 months</u> <u>2 years</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>March 11</u> , 19 <u>60</u> , to <u>March 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 8, 1967</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>H.R. Trapnell</u>									22b. DATE SIGNED <u>May 17, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>H.R. Trapnell, M.D.</u>									22d. ADDRESS <u>Federalsburg, Maryland</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>May 19, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Federalsburg, Maryland</u>			
24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Maryland</u>					25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
06491						06478					
1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>				c. LENGTH OF STAY IN 1b <u>6</u> years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u> 05-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>411 Railroad Avenue</u>						d. STREET ADDRESS <u>411 Railroad Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
		<u>BERTHA</u>		<u>EDNA</u>		<u>WILLIAMSON</u>		<u>May</u>		<u>11</u> <u>1967</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 21, 1902</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Caroline Co., Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Edward Sharp</u>						14. MOTHER'S MAIDEN NAME <u>Ebbie Dean</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-05-8828</u>		17. INFORMANT Address <u>W. Lacey Williamson, Federalsburg, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Cervix with</u> <u>generalized metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>171X</u> DUE TO (c) <u>14 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>14 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>65</u> , to <u>May 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 11, 1967</u> , and that death occurred at <u>8:55</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Frank M. Anderson</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>May 12, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Frank M. Anderson, M.D.</u>						22d. ADDRESS <u>Federalsburg, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Federalsburg, Maryland</u>				
24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Maryland</u>						25a. REC'D BY REGISTRAR <u>MAY 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

3. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

4. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.

5. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methods used in the study. This includes a description of the experimental design, the data collection procedures, and the statistical methods used to analyze the data. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references.